CSHCS ENROLLMENT PACKET
State Form 49006 (R3/2-07)

Indiana State Department of Health
Maternal & Children's Special Health Care Services

THIS PACKAGE CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC.3.2-10 and 410 IAC 3.1-2-18

INSTRUCTION: If you have questions, please call 1-800-475-1355 Eligibility Option and ask for Training Coordinator.

Children's Special Health Care Services Enrollment Packet consists of 15 pages. Please **print** all information except where signatures are required. The program serves Indiana residents age 0-20. Applicants with Cystic Fibrosis can apply to this program **at any age**, but must be financially eligible.

Remember the **Application Date** must be on all pages where a date is required. Exception – page 13 should be current date because this form is only good for 60 days. The completed enrollment packet must be submitted to CSHCS within 30 days of the application date.

Page three: Enrollment Form Checklist. This checklist will help to ensure that you are submitting all necessary documents. If you are sending this application for diagnostics, the family must be financially eligible for CSHCS. If family refuses to cooperate or does not return requested documentation, submit application for denial and check appropriate reason.

Page four: Applicant's and parent/guardian information. The **Application Date** is the date you are completing the form. Mark the form New Enrollment; however, if you know that the person is reapplying to the CSHCS program, mark Re-application. The remainder of the form is self-explanatory. There are some exceptions: a) only a parent (regardless of age) or legal guardian can sign this application, so if the applicant is a Ward of the County/State, the caseworker's information goes on the 1st line for parent/guardian and the foster parent's information can go on the 2nd line; b) a surrogate parent (First Steps) can not sign this application.

We need to know why they are applying to CSHCS. This can be exactly what the parent/guardian tells you. This is also where you will put your information as the Intake Person. If you know that this applicant is followed by a First Steps Service Coordinator, please complete that information too; otherwise, leave it blank.

Page five: Household Members and Income Information. List all persons living under roof as an Economic Unit regardless if related or not (i.e. mom, child & mom's boyfriend). We would count boyfriend's income. A pregnant woman is considered 1 person. We do not count the child until it is born. There are no special codes to use, just put m=mom, d=dad, a=applicant, b=brother, etc. There are some exceptions, so if you have an unusual situation, call. They are too numerous to list. Complete across the table and for Insurance, put Y or N.

The CSHCS program counts **ALL** income for the household and we use GROSS amounts. The CSHCS program requires that Income documentation be submitted with the application and **preferred documentation** is latest Federal 1040 that was filed. If they state they have no income, ask, document and request written and signed statements on how they pay rent, buy food, pay utilities, etc. You will sign & date the bottom of the income page.

Page six: Medical Insurance Information form – complete boxes 1 & 2 always. Boxes 3-7 should be completed only if there is private insurance.

Page seven: Social History Interview – self explanatory.

Page eight: Medicines and Medical Equipment – self explanatory.

Page nine & ten: Hoosier Healthwise Information

Page eleven: Continuation of Hoosier Healthwise Information. Important, the parent/guardian or applicant ***must sign*** the Assignment of Rights box. However, they only need to initial the **first paragraph** in the second box. The CSHCS program does not require that applicant participate in Hoosier Healthwise package C, only that they apply for it.

NOTE: if strongly suggested that you encourage the parent/guardian/applicant to accept Hoosier Healthwise as CSHCS is not a comprehensive coverage. Although the program will cover a lot for the participant, a lot is left uncovered. Easy example, if the participant is on the program for Asthma and breaks a leg, CSHCS will not cover the E.R. visit for the leg.

Page twelve: Medicaid Form – this form is self explanatory and needs to be submitted either with the application or mailed to CSHCS. If it is to be mailed, YOU must send it to the county department of family resources where the applicant lives.

Page thirteen: Application for Enrollment form – self explanatory

Page fourteen: Authorization for the Collection of Information – self explanatory

Page fifteen: Authorization to Release and Share Medical Information – complete one for each provider that the parent/guardian/participant says can verify diagnosis. *If the parent/guardian/ participant has medical that can be submitted with the application, there is no need to send this form anywhere. However, the form must be completed and submitted with the application.*

This form may be copied to accommodate additional providers. When sending to more than one provider, remember to copy the back of the form. **A copy or copies of the completed form must be submitted with the application.**

Page seventeen: Last page of enrollment packet – Physician's Health Summary Form. This page is to be mailed, along with the Authorization to Release & Share Medical Information form, to the provider or providers who the parent/guardian/participant says can verify diagnosis. If the parent/guardian/participant has medical it can be submitted with the application and there would be not need to mail the form; however, it should be sent with the application.

NOTE: If you have any questions, please call 1-800-475-1355, option 4 and ask to speak with Judi. The direct number is 317-233-5571.

ENROLLMENT CHECKLIST
Part of State Form 49006 (R3/2-07)

Applicant's Name _____ D.O.B. _____

- _____CSHCS Enrollment Forms complete with Signatures and Date
- _____Income page signed, income documentation attached
- _____Hoosier HealthWise: _____ date family informed that they must apply and/or a copy of Enrollment form mailed to family's county DFR office. **(THIS IS MANDATORY IF CHILD IS NOT CURRENTLY ENROLLED IN HOOSIER HEALTHWISE).**
- _____Medical Insurance Information page completed (if applicable), signed and dated, copy of either HHW card or insurance card (front & back) attached.
- _____Authorization for the Collection of Information form signed and dated
- _____HHW Assignment of Rights page signed and dated
- _____ Medicaid Page completed and sent to DFR office
- _____Application for Enrollment with CSHCS page signed and dated
- _____Copy(ies) of Authorization to Release & Share Medical information completed, signed and dated attached **(original(s) are to be sent to medical provider to verify diagnosis).**

_____APPLICATION IS FOR DIAGNOSTICS (applicant is financial eligible for CSHCS)

_____APPLICATION IS RECOMMENDED FOR DENIAL ***(if the application has been signed by the parent/legal guardian/applicant it must be submitted)***

___ Voluntary Withdrawal of Application
___ Failure to Apply for Medicaid/HHW
___ Failure to Disclose Income
___ Other: _____
___ Applicant is Over Age 21
___ Failure to Complete Application Process
___ Family is Financially Ineligible

Please mail application and all documentation within 30 days to:

Maternal & Children's Special Health Care Services
ATTN: Eligibility Section
Indiana State Department of Health
2 North Meridian St., Section 7-B
Indianapolis, IN 46204

CSHCS ENROLLMENT APPLICATION
Part of State Form 49006 (R3/2-07)

INSTRUCTIONS: Please Print All Information in Blue or Black Ink

County of Residence of Applicant _____ **Application Date** _____ Enrollment Date _____

New Enrollment _____ Reapplication _____

Applicant's Name _____DOB: _____
Last First MI

Social Security # _____ M ___ F ___ Race _____ Ethnicity _____

Current Address _____

City _____ ZIP code

_____

Home telephone ( ) _____ Work telephone ( ) _____

Parent/Guardian _____

Current Address _____

City _____ ZIP code

_____

Home telephone ( ) _____ Alternate telephone ( ) _____

Work telephone ( ) _____

Parent/Guardian _____

Current Address _____

City _____ ZIP code

_____

Home telephone ( ) _____ Alternate telephone ( ) _____

Work telephone ( ) _____

Primary language spoken in home: English _____ Spanish _____ Other _____

Reason for applying to CSHCS: _____

Intake Personnel: _____

Site Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: ( ) _____ Fax: ( ) _____

Ongoing Service Coordinator: _____

Site Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: ( ) _____ Fax: ( ) _____

HOUSEHOLD MEMBERS and INCOME INFORMATION

Part of State Form 49006 (R3/2-07)

List all persons (including participant) who live in your home and provide requested information for each individual. This includes children who are in college.

Name	Relationship to applicant	DOB	Gender	Race/Ethnicity	SSN#	√ if applying for Healthwise	Insurance

CSHCS Household Size: _____

Income Verification must be provided for everyone receiving income that is part of your household. Include copies of all documentation used to prove income. Preferred documentation is the most recent 1040 Federal tax form; however, if income has changed from last 1040 report, still provide the 1040, but also provide your 3 most recent consecutive check stubs and write a note of explanation. Other acceptable documentation is an Employer's letter (on company Letterhead) signed and dated, showing how much you earn and how often received. Attach additional sheet if necessary.

	1		2		3		Totals
NAME OF PERSON RECEIVING INCOME →							
Wages/Fees/Commissions/Tips/Sick Benefits	Gross Amount	How Often	Gross Amount	How Often	Gross Amount	How Often	
Social Security or SSD or SSI (SSI **NOT** counted as income for CSHCS, but must be reported)							
Dividends/Interest on Savings							
Unemployment Compensation/Strike Benefits							
Alimony/Child Support/TANF (provide documentation)							
Regular Contributions from persons not living in the household (provide name & statement)							
Other income not listed above includes: Trustee Assistance, Farm Income, Rental Income, Pensions, Annuities, Trusts, Royalties, Estates, and Military Compensation							

If you have no income, how do you pay your bills? (supply written & signed statements) _____

_____

Income Documentation was verified by: _____ Date: _____

(Signature of Intake Personnel)

MEDICAL INSURANCE INFORMATION

Part of State Form 49006 (R3/2-07)

Complete a <u>new</u> form for each insurance coverage.

1. PARTICIPANT IDENTIFYING INFORMATION:

Name: _____ D.O.B.: _____ CSHCS #: _____

FS Child ID#: _____

Address: _____ IN

Street City ZIP Code

2. HOOSIER HEALTHWISE INFORMATION – HOOSIER HEALTHWISE NUMBER: _____

Complete One:

Current Coverage Effective Date: _____

Pending Application Date: _____

Not Financially Eligible Date of Denial: _____

Medicaid Disability with/without spend down $_____ **(if known)**

Did participant lose health insurance coverage in the past 3 months?

☐ YES ☐ NO Date coverage ended: _____

Reason for loss of insurance: _____

3. POLICYHOLDER INFORMATION:

Name: _____ Relationship: _____ Telephone: ( ) _____

Address: _____

Street City State ZIP Code

4. INSURANCE COMPANY INFORMATION: ☐ **Primary** ☐ **Secondary**

Name: _____ Telephone: ( ) _____

Billing Address: _____

Street City State ZIP Code

Check As Applicable: Is this Coverage: _____ Through Employer _____ Self Purchase _____ Union _____ HMO Policy _____ PPO Policy

5. POLICY NUMBER: _____ Member/I.D. #: _____ Group/Acct. #: _____

Effective date dependent will be covered under policy: _____ Termination Date: _____

6. EMPLOYER INFORMATION:

Name of Employer: _____

Address: _____

Street City State ZIP Code

Telephone: ( ) _____ Start Date: _____

7. COVERAGE INFORMATION: Check As Applicable:

A. Second Insurance Company Coverage? ☐ YES ☐ NO

B. Therapy Services Covered: ☐ OT ☐ PT ☐ Speech

C. Co-Payments? ☐ YES ☐ NO

Office Visit Amt: $ _____ Specialist Amt: $ _____

Emergency Room Amt: $ _____ Other Amt: $ _____

Prescriptions Amt: $ _____ DME Services Amt: $ _____

D. Deductibles? ☐ YES ☐ NO If YES, Amt: $ _____

E. Maximum Out of Pocket Expense $ _____

F. Is there a pre-existing clause? ☐ YES ☐ NO

Effective Date: _____

G. Is there a dental plan? ☐ YES ☐ NO

Name of plan if different: _____

Effec. Date: _____ Term. Date: _____

H. Lifetime maximum? ☐ YES ☐ NO

$ _____ per person $ _____ per family

I. Conditions/Exclusions: _____

SOCIAL HISTORY INTERVIEW

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Applicant's Name _____ DOB: _____

Health care received in the past 12 Months (copy additional pages of this section as needed.) List the primary care physician for all well-child care including immunizations and illness. List the dentist (if applicable), clinics and other medical care providers by specialty type.

Name of Primary Care Physician:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Name of Dentist:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Name of Specialty Care Physician:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		

MEDICINES and MEDICAL EQUIPMENT

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What type(s) of adaptive equipment is currently used by your child? (√ accordingly)

☐ Wheelchair ☐ Walker ☐ Splints/AFO's (ankle, foot, orthosis) ☐ Eye Glasses
☐ Adaptive Seating ☐ Adaptive Bathing ☐ Assistive Communication Device(s) ☐ Braces
☐ Feeding Aids ☐ Hearing Aids ☐ Other:_____

What medical, health equipment or supplies are routinely used by your child? (√ accordingly)

☐ Apnea Monitor ☐ Oxygen ☐ Prescription Drugs ☐ Tube Fed
☐ Ventilator Dependent ☐ Other:_____

Medication	Dosage	Frequency	Purpose

Current Medications (specify dose, frequency and purpose)

Is the applicant currently on a special diet? ☐ YES ☐ NO Type: _____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

HOOSIER HEALTHWISE INFORMATION:

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There are 4 Benefit Packages as explained below. We will determine your eligibility for the most benefits possible based on your situation and family income. If you are applying for Hoosier Healthwise for your children, we will ask you to agree to pay the premiums and co-payment amounts that are required for Package C. If you do not agree to do this, we will still check eligibility for the premium-free plans.

- **Package A – Standard Plan**
  Provides comprehensive health care coverage to eligible adults and children. There are no premiums.

- **Package B – Pregnancy Coverage**
  Provides coverage for pre-natal care, treatment of conditions that may complicate the pregnancy, delivery, and 60 days of after-pregnancy care. There are no premiums.

- **Package C – Children's Health Plan**
  Provides comprehensive health care coverage for children under age 19. There is a premium based on family income and the number of children covered. Your interviewer will tell you the current premium rates.

- **Package E – Emergency Services Only**
  Provides coverage for treatment of serious medical emergencies. This plan is for certain immigrants who do not meet the necessary immigration status requirements for full coverage under the other benefit packages.

Your Rights and Responsibilities as a Hoosier Healthwise Applicant and Member

1. Eligibility for benefits is considered without any regard to race, color, sex, age, disability, or national origin. We ask about your racial-ethnic heritage to comply with the Federal Civil Rights Law, however you are not required to provide this information. If you choose not to provide this information we will indicate an ethnicity/race category for you for data collection purposes.

2. Certain information given on your application, such as your income, must be verified. If you cannot get the necessary papers, you will need to sign a release form so that we can get them for you.

3. You must provide accurate information. A person who gives false information or misrepresents the truth is committing a crime and can be prosecuted under federal law or state law, or both. The value of benefits received by a person who was not entitled to receive them must be repaid to the Hoosier Healthwise program.

4. Information you give is kept confidential under state and federal law.

5. **IF YOU MOVE, please tell us your new address so that important mail about your application and membership will reach you without delay.** Also, tell us if you or your child(ren) become covered under other health insurance. Your interviewer will tell you more about reporting changes to the information you give on your application.

6. A Social Security Number must be given for each applicant who can legally have a number. An applicant who does not have a number must apply for one. This requirement does not apply to certain immigrants who cannot have a number and therefore are eligible only for the limited benefits under Package E. The number you provide will be used to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development, and other state and federal agencies. We ask for the Social Security Numbers of family members, who are not applying for health coverage for themselves, however, it is not required that you provide the numbers.

7. We will send you a notice telling you the decision on your application. You may request a fair hearing if you disagree with any decision about your eligibility, or if your application is not processed within 45 days.

8. The immigration status of non-citizens who are applying for health coverage for themselves is subject to verification by the Immigration and Naturalization Service (INS). However, the Hoosier Healthwise Program does not report undocumented immigrants to the INS.

9. Please *carefully* read the following about assignment of medical rights and establishment of paternity. *Ask your caseworker if you have any questions.*

   (a) If you are applying for health coverage only for your children and not for yourself, we do encourage you to take advantage of the free service of having paternity established for children who do not have legal fathers. However, if you prefer not to have paternity established for your children, then do not sign the medical assignment.

   (b) If you are applying for health coverage for yourself and are age 18 or older, you are required to assign medical rights. This includes rights to medical support and payment for medical care that you have on behalf of yourself and any other person under this application whose rights you can legally assign. If you do not do this, you will not be eligible. Cooperation in obtaining medical support or third party payments, including having paternity legally established for your children, is required. You must tell us about any legal or administrative actions you may take to obtain payment for medical care received, such as a personal injury settlement. Note the exemption from cooperating in item (d).

   (c) The establishment of paternity is an important service for Hoosier Healthwise members that benefits children who do not have legal fathers. Except for children enrolled in Package C, there is no cost for this service. When you sign the medical assignment, this service becomes available to you. If the children are eligible for Hoosier Healthwise, we will forward information to the Child Support Office of your local county prosecutor and they will help you with the next steps.

   (d) If you believe that cooperating with medical support requirements, including having paternity established will cause physical or emotional harm to the children, you may ask to be excused from this requirement.

Your children's eligibility for Hoosier Healthwise will not be affected if you do not cooperate in establishing paternity or do not sign the medical assignment on the application.

10. FOR MEMBERS ENTITLED UNDER PACKAGE C, there is a cap on the amount of cost-sharing that you will have to pay. This amount is 5% of your annual income before taxes. It is your responsibility to keep track of the amount of premiums and co-payments you pay. If you reach the cap, you will need to contact the Office of Family and Children and provide your receipts so that you will no longer have to make payments.

11. If you believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave., Suite 240, Chicago, Illinois, 60601. You may call them at (800) 368-1019 or, for TDD calls, (800) 537-7697.

Assignment of Rights
(Please read Item # 9 on the "Important Information about Hoosier Healthwise" page.)

I hereby assign to the state of Indiana, my rights to medical support and payments for medical care, which I have on behalf of myself and other persons under this application whose rights I can legally assign.

Signature: _____ Date: _____

Please read the following statements and initial if you agree, and sign your application below.

___ I certify under penalty of perjury, that all of the information I have provided is complete and correct to the best of my knowledge and belief and that I have received the notice entitled "Important Information about Hoosier Healthwise" and understand what it states.

___ If the children applying for health coverage on this application, are found to qualify for Package C - Children's Health Plan, I agree to pay the premiums and co-payments that are required.

Your Signature: _____ Date: _____

Signature of witness if signed with X": _____

CONFIRMATION OF HOOSIER HEALTHWISE
Part of State Form 49006 (R3/2-07)

INSTRUCTIONS: To be filled out by Medicaid personnel or designee and sent to CSHCS

Applicant's Name: _____ DOB: _____

Address: _____

City: _____ ZIP: _____

Pending Medicaid Case #: _____ Date: _____

Current Medicaid #: _____ Effective: _____

Not Eligible for Medicaid Reason(s): _____

_____

Caseworker's Signature: _____Date: _____

County: _____

Attn: ISDH/MCSHC
2 N Meridian
Section 7 B
Indianapolis, IN 46204

Fax: 317-233-8462

Application for Enrollment
Children's Special Health Care Services (CSHCS)
Part of State Form 49006 (R3/2-07)

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Applicant must sign all copies in ink in the presence of the person authorized to accept the application who may be an employee of the Indiana State Department of Health, the County Division of Family and Children, Family and Social Services Administration and/or any other entity approved by the Director.
2. Once completed and signed, an application shall never be altered by the applicant or by an employee or designee of the State Department, County, or Family and Social Services Administration. No application shall be destroyed unless proper legal procedures are followed. Provide a copy to parent, file, and send original or copy to CSHCS and/or MCH programs with completed enrollment forms.

PARTICIPANT RIGHTS INCLUDE:

1. Fair treatment regardless of race, color, creed, national origin, age, gender, or disability.
2. An administrative hearing may be requested. Any decision affecting your participation in CSHCS, which you do not agree with, can be reviewed. You must request a hearing within 15 days from the day of notice of the decision. You shall do this in writing. More information on the hearing process will be given to you, in writing, at the time the decision is made.

STATEMENT OF AGREEMENT:

In support of this application, I will, when requested, supply such information as I can to persons authorized to request and receive it.

I hereby certify that all of the information in the Combined Enrollment Form, including the verified income, is true and correct.

I hereby give consent for routine health care, diagnostic evaluation and medical treatment under Children's Special Health Care Services and/or Maternal and Child Heath Services. I understand that I must use all available health insurance and/or Medicaid coverage for the child's healthcare before the Indiana State Department of Health makes any payments. In the event that the insurance payment is made directly to my spouse, or me I will pay said payment to the Indiana State Department of Health as a repayment for costs paid by the Department.

I understand that the availability of and the provision of health care services included in the basic service component and the limited service component is contingent upon the availability of program funding.

I hereby consent to the release of personal and financial record information on this form to the Indiana State Department of Health for the purposes of verifying eligibility and performing program evaluations.

I, being the applicant (parent or legal guardian) understand the application date for enrollment in the Children's Special Health Care Services Program will be the date of this signature as long as I provide the financial and social information necessary to complete this application, within the thirty days, to the CSHCS Program Designee (interviewer completing this application). I understand that if I do NOT provide this information, this application will be denied for failure to cooperate in the application process. I understand that I will be required to initiate a new application with updated information and sign a new signature page if I want to go forward with the application process. The new signature date will become the date of the application and the effective date will be adjusted accordingly.

I understand that the approved health and welfare agencies of the Indiana State Department of Health will maintain confidentiality of this information pursuant to IC 16-39, IC 5-14-3-4(a)(9), 42 CFR§51a, 112, and 7CFR§246.26(d).

Participant's Name (*****May sign for self if over 18 years of age or older)

*****Signature of Participant/Parent/Legal Guardian	Relationship to Applicant	Date
Signature of Participant/Parent/Legal Guardian	Relationship to Applicant	Date
Signature of Intake/Ongoing Coordinator/Interviewer		Date

Authorization For The Collection Of Information
Children's Special Health Care Services

Part of State Form 49006 (R3/2-07)

PLEASE REVIEW THE FOLLOWING INFORMATION AND HAVE YOUR INTAKE or SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

Applicant's Name: _____ DOB: _____

We are asking for your permission as parent/legal guardian/emancipated minor/person 18 years of age or older, to collect demographic and service information about you and/or your child and store it electronically in the Indiana State Department of Health (ISDH) and/or Family and Social Services Administration (FSSA) database system(s).

The program you are enrolling in is the Maternal and Children's Special Health Care Services, a program that provides the primary, specialty, diagnostic and dental-related care for medically and financially eligible children 0-21 years of age. Services available through this program include screening, evaluation and assessment, service coordination, due process and procedural safeguards, health and medical services that are made available based upon the needs of the child and family.

This authorization covers certain medical ("Protected Health Information"), social and financial information about the eligible child and family, unless an exception is noted below, including: child/family demographic information; health visit information; infant/child visit data; disability/risk factors; problems or factors that prevent the eligible child and family from receiving appropriate services or medical care; appointments made and services received; Individualized Family Service Plan (IFSP) activities, care plans and family financial eligibility information.

Based upon the information collected during the eligibility determination and enrollment process, a multidisciplinary team will work with you to determine your child's needs for services. With your informed, written authorization, only those health care professionals and service providers with a direct need to know and with authorized security clearance will have access to the electronic file or authorizations for eligibility determination services that are required and authorized by you as your child's parent/legal guardian. Statistical and program information, without any child or family identifying information, will be sent to State and Federal agencies that fund these services to meet various reporting requirements.

Individually designated and signed releases are maintained in your child's record at the local System Point of Entry/ISDH/MCH clinics that indicate individuals with whom you have given your informed, written authorization for reciprocal communications including the sharing and receipt of reports. The person(s) receiving this information has a legal and ethical duty to keep the information in a confidential and private manner, and will not release it to anyone else without your written permission unless allowed by law.

By signing this authorization form, you agree to allow information to be collected through the System Point of Entry or state intake personnel for the electronic database collection systems. All aspects of the data collection, maintenance and utilization are protected under the Family Education Rights and Privacy Act (FERPA). All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10, 42 CFR §51a. As the parent/legal guardian, access to information stored in the database is also available to you upon request for inspection or copying. As legal guardian, you authorize the ISDH and/or FSSA database system(s) to distribute information collected during the eligibility determination/enrollment process and service delivery period to the following:

1. Indiana Family and Social Services Administration, the Division of Disability, Aging and Rehabilitation Services, First Steps, and Hoosier Healthwise
2. Indiana Department of Education
3. Indiana State Department of Health
4. U.S. Departments of Education, and Health and Human Services, for the purposes of financial/program audit and monitoring purposes as required by various federal and state regulations.

By signing this authorization, I acknowledge that I have read and understand the information for collection and sharing of data contained on the forms. The authorization will remain in effect no longer than 12 months from the date of my signature. **I understand that I have the right to revoke this authorization, if the revocation is in writing, except to the extent that action has been taken in reliance on this authorization.**

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law.

_____ _____

Signature of parent/legal guardian/applicant (if 18+ or is an emancipated minor) Date

_____ _____

Signature of Intake Personnel Date

Authorization To Release And Share Medical Information
Children's Special Health Care Services

Part of State Form 49006 (R3/2-07)

PLEASE REVIEW THE INFORMATION ON THE REVERSE SIDE OF THIS FORM, AND HAVE YOUR INTAKE/SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

I/We, _____ hereby authorize:
Parent/Legal Guardian Name(s)

_____
Physician/Health/Medical Care Provider or Facility Name

_____
Practice/Hospital (as applicable)

_____
Street Address/Post Office

_____
City/Town State ZIP Code

To communicate and to share information including medical ("Protected Health Information"), in writing and conversation, with the First Steps Early Intervention Service System and Children's Special Health Care Services regarding:

_____
Child's Legal Name Date of Birth

_____
Street Address/Post Office

_____
City/Town State ZIP Code

This authorization includes the following types of information: (as checked √)

_____ Medical record information including but not limited to: progress notes, laboratory and x-ray reports, history and physical, discharge summary and treatment plan(s)

_____ Written specialty reports including assessments

_____ Medical record information required to determine eligibility, participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP)

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS RELEASE, AS CONTAINED ON THE REVERSE SIDE OF THIS FORM.

_____ _____
Signature (Participant if over 18 years of age) Date

_____ _____
Signature (Parent/Legal Guardian) (Surrogate Parent-for education only) Date

_____ _____
Intake/Service Coordinator/Interviewer/Witness Date

- OVER -

Authorization To Release And Share Medical Information
Maternal And Children's Special Health Care Services
Part of State Form 49006 (R3/2-07)

INSTRUCTIONS: Please read this carefully before signing. If you have questions, please ask your service coordinator care coordinator (if applicable)

The purpose of this release is to collect information necessary to determine the participant's eligibility for the programs listed above, and to plan and provide essential and necessary services as determined through the multidisciplinary team process. I hereby authorize the medical provider named on this form to release to the staff of Maternal and Child Heath Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the medical, educational, developmental, social, and rehabilitative needs for the participant named on this form. Authorization is also granted for release of information by Maternal and Child Heath Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services to accomplish referrals for service to other individuals where an informed, written consent has been obtained from me as the parent/legal guardian; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, and planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal, and/or video format. As the parent/legal guardian, or surrogate parent (for educational purposes only, in the event one is appointed for early intervention services), I understand that I may revoke this authorization shown on the reverse of this form at any time in writing. The request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first. A copy of this "Authorization to Release and Share Medical Information" has the same effect as an original.

The information collected as a result of this consent shall be maintained in the participant's record which will be located at Maternal and Child Health Services, and/or the Indiana Hoosier Healthwise, and/or First Steps, and/or Children's Special Health Care Services. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and Release of Medical Records Law IC 16-39, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10.

Physician's Health Summary
Children's Special Health Care Services

Part of State Form 49006 (R3/2-07)

INSTRUCTIONS: Your patient is currently in the evaluation process for eligibility for CSHCS and/or early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). All components of this evaluation are required to be completed within 45 days. The health summary request is an initial step in this process. Your participation in the evaluation to determine the child's eligibility is requested by completing and returning this form in the enclosed envelope. If you have questions, please contact the Intake/Service Coordinator listed on the cover letter. Your participation in this activity is greatly appreciated.

IDENTIFYING INFORMATION

Child's Name: _____ D.O.B.: _____

Parent/Guardian: _____

Reason(s) for Referral: _____

MEDICAL INFORMATION

Birth Place: _____ Birth Weight: _____ (grams) _____ (lbs/oz) Apgar _____ Gestational Age: _____

Length of Hospital Stay: _____ Past Hospitalizations/Illnesses: _____

_____

ADDITIONAL COMMENTS **(please include any recommendations you may have):** _____

_____

CURRENT HEALTH STATUS

Present **diagnosis/illnesses** including ICD/DSM CODE(S): _____

_____

Current Medications and frequency : _____

_____

Medical Precautions: _____

Immunization Information: DPT/DTaP _____ _____ _____ _____ DT _____ _____ TB _____ _____ Varicella _____
IPV/OPV _____ _____ _____ _____ MMR _____ or Measles _____ Mumps _____
Hep B _____ _____ _____ _____ Hib _____ _____ _____ _____ Rubella _____

Physical Status: _____

Vision: _____ Hearing: _____

Date Screened/Tested: _____ Date Screened/Tested: _____

Developmental Screening: Date: _____ Results: _____

Date Last Seen: _____ Other Physician Referrals Made: _____

If indicated, I authorize the above named child to be seen as follows:

_____ Physical therapy evaluation, as indicated
_____ Occupational therapy evaluation, as indicated
_____ Speech therapy evaluation, as indicated

_____ _____
Physician's Signature (Primary/Specialty Health Provider) Date

_____
Physician's Name (Please Print)

_____
Physician's Address/Telephone #

Return to: **ISDH/CSHCS**
2 N Meridian St., Section 7B
Indianapolis, IN 46204

Telephone: 1-800-475-1355
Fax: 317-233-8462